

MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. 149Primary Registration District No. 1002 Registrar's No. 618STATE FILE NUMBER 62-001899

FILED FEB 15 1962

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City, Missouri		c. CITY OR TOWN Kansas City	
Length of stay in 1b 25 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Downtown Hospital		d. STREET ADDRESS (If outside, give location) 3108 E. 25th Street	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Stella Middle Mothersbaugh Last Mothersbaugh		4. DATE OF DEATH Month 1 Day 31 Year 62	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-11-1895
9. AGE (last birthday) 66		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Finisher		10b. KIND OF BUSINESS OR INDUSTRY Shukert Fur Co.	
11. BIRTHPLACE (City and state or country) Marshall, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME John Heehart		13b. MOTHER'S MAIDEN NAME Margaret Joseph	
14. NAME OF HUSBAND OR WIFE Samuel J. Mothersbaugh		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT Address Samuel J. Mothersbaugh Same	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Ventricular Failure, due to Renal		INTERVAL BETWEEN ONSET AND DEATH 1-31-62	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Insufficiency and Pneumonia			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Uremia and Kidney Failure, & Generalized Arteriosclerosis		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1958 to 1-31-62 and last saw her alive on 1-31-62 Death occurred at 1-31-62 6:25 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE E. Robert Hughes MD (Degree or title)		22b. ADDRESS 1222 McGee - Kansas City, Mo.	
22c. DATE SIGNED 2-1-62			
23a. NAME OF CEMETERY OR CREMATORY Ridge Park		23b. LOCATION (City, town, or county) (State) Marshall, Mo	
24. FUNERAL DIRECTOR Melody Mc Silbey, Esq ADDRESS [REDACTED]		25. DATE RECD. BY LOCAL REG. 2-2-62	
26. REGISTRAR'S SIGNATURE Ruth Long			

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.